

Policy Implementation For The Disabled To Access Healthcare Services In Rural Spaces Of King Cetshwayo District Municipality

Sibongiseni. L Sigwaza ,Nokukhanya.N Jili*

University of Zululand

*Corresponding author:

Nokukhanya.N Jili, University of Zululand

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Introduction

Disability is an undesirable socio-politically defined phenomenon, yet a reality for persons across the globe. This phenomenon generally affects persons from a lower socio-economic status and is largely associated with access to healthcare, because those who live with disabilities face multiple healthcare related challenges globally

Healthcare access disparities that challenge different nations are deemed unjust and unfair by the World Health Organisation (WHO), and further are avoidable [1]. Numerous factors are responsible for healthcare access disparities, and disparities affect both developed and developing countries. The most dominant disparities are those between urban and rural spaces, as they are prevalent in almost all countries, and urban-rural disparities are largely linked to socio-economic factors [1]. Furthermore, rural residency correlates with low educational attainment, which implies low socio-economic status [2]. Race, class and ethnicity are other causal factors associated with healthcare access disparities (James, Moonsinghe, Wilson-Frederick, Hall, Penman-Aguilar and Bouye, 2017). Scrutiny of literature indicates that healthcare access disparities affect all nations in different degrees, with urban-rural healthcare access disparities being dominant. Cohen et al. (2018) assert that causal factors responsible for these disparities are understudied. Doogan et al. (2018) state that approximately 56% of the global rural population are affected by healthcare access disparities that they do not have health coverage, and this cannot be compared to the global urban population of 22% without health coverage. In rural spaces, people with disabilities are the worst affected by the effects of healthcare access disparities, due to facing barriers that non-disabled people do not face. Scholarly evidence indicates that disabled people face attitudinal barriers from healthcare professionals, stigma and discrimination from the broader community, and challenges in physical access to healthcare facilities [3].

In developing countries, mixed evidence emerged concerning healthcare access disparities. Women with disabilities reported mixed outcomes concerning healthcare access, as others reported better healthcare, while others reported the opposite. This can be linked to very few healthcare workers receiving no training on disability. Further, covert discrimination towards the disabled population has been observed. In some sub-Saharan countries, evidence indicates that the majority of people reside in rural spaces, hence factors such as lack of transport, unavailable services, inadequate medication or equipment and higher costs are barriers to healthcare access and disabled people are adversely affected [4]. Furthermore, factors such as low educational attainment, poverty and unemployment are barriers to healthcare access.

Concerning disabled people, they have more unmet healthcare needs compared to people without disabilities, especially in rural spaces [5]. Disabled people are also affected by factors such as inadequate training of healthcare professionals vis-à-vis disability, poverty, inadequate resources, stigma and negative attitudes associated with disability. Lastly, disability correlates with increased healthcare expenditure [3].

When it comes to healthcare policy making and implementation, different phenomena emerge in scholarly research. The National Department of health is mandated with policy making at the national level, while provincial departments of health make provincial policies in South Africa. Molete, Stewart, Bosire and Igumbor find another phenomenon where there is a discord between policy and practice, and a lack of standardised policy implementation [6]. Concerning mental health for children and adolescents, Mokitimi, Schneider and De Vries posit that there are no provincial policies, hence mental disability is not catered for as far as policies are concerned [7].

Literature Review

This paper discusses the concepts of healthcare, healthcare access, disparities, disability amongst others; as well as analyses and interprets healthcare to establish how implementation of policy to access healthcare affects the disabled in rural spaces. Access to healthcare in South Africa is also examined. Policies which generally affects access to healthcare and moreover the disabled in South Africa and its implementation in rural spaces is also examined.

Conceptualisation of Healthcare and Healthcare access.

Allen-Duck, Robinson and Stewart conceptualise healthcare as systematic interventions to a population to achieve desired health outcomes [8]. It can be inferred that healthcare is a complex phenomenon; one which is regulated and characterised by numerous actors, both state and non-state, whose end goal is to achieve desired health outcomes. In conceptualising access to healthcare, Fortney, Burgess, Bosworth, Booth and Kaboli posit that it is largely determined by patient-to-provider physical meetings [9]. The patient has to travel to a healthcare provider to access the service. Fortney *et al* state that physical meetings between the patient and the healthcare provider are traditional methods of access and largely utilised method, despite the pedestrian growth of digital access. Fortney *et al* also posit that access is subject to geographical, temporal, financial, cultural and digital dimensions. Wang and Luo hold that access to healthcare is subject to spatial and non-spatial factors. Spatial factors are based on geography and time, while non-spatial on socio-economic and demographic characteristics of the population. Therefore, it can be inferred that access to healthcare is largely a physical encounter between a provider and a patient. However, there are other factors such as race and class which determines access. As the argument of this paper focuses on disability, it becomes necessary to conceptualise disability.

Conceptualising Disability

conceptualise disability as a health outcome associated with the decline of infectious diseases and increase of non-communicable diseases (NCDs). Disability is then a result of various health outcomes such as disorders, diseases and injuries. Okoro, Hollis, Cyrus and Griffin-Blake associate the prevalence of disability with poverty. There appears to be a correlation between disability and poverty. Furthermore, disability correlates with unmet healthcare needs. Friedrich (2017) holds that the major causal factor of disability is depression and it affects persons in low and middle-income countries. Although disability is associated with poverty, Banks, Kuper and Polack (2017) lament that there is a lack of robust, empirical research to substantiate this association. Therefore, although the majority of the disabled reside in less developed countries, there is still a need to link disability and economic development empirically.

The feminist concept of disability is based on the premise that the lived experiences of women with disabilities differs from those of men with disabilities. Women with disabilities are in a more disadvantageous position compared to men with disabilities. Be

states that despite movements and organisations for PWDs, disabled women face greater exclusion even amongst organisations and movements for the disabled [10]. Therefore, there is a need for gendered conceptualisation of disability. The disabled are conceptualised as needing care, dependent and passive, which results in PWDs being under the control of others. There is a need for the reconceptualisation of care, dependency and passivity to enable PWDs to have a meaningful life, despite disability [10]. From a different feminist perspective, Rohrer (2005) posits that the disabled are conceptualised as special, and then segregated from non-disabled people. This results in the disabled being excluded and impedes the fulfilment of self-determination right.

Disability, Exclusion and Poverty

The disabled are prevalent globally. Yeo (2001) states that the majority of the disabled are victims of chronic poverty and argues that poverty is not due to lack of resources but exclusion. Although there are policy initiatives to alleviate poverty, most of those policy initiatives focus on those who are easy to lift from poverty and largely excludes PWDs. The author concludes that the disabled are excluded in most facets of life, including sports, religion, politics and academia.

In the South African context, there has been a massive reduction of absolute poverty in households with a disabled member due to disability grant, yet other measures of disability such as access to education and employment is still limited for the disabled (Loeb, Eide, Jelsma, Toni and Maart, 2008). Furthermore, Loeb *et al* (2008) state that the concept of poverty has changed recently because it is no longer measured as a function of consumption, it is based on living standards and how institutions serve people. Therefore, poor people have low living standards and are poorly served by institutions. Banks, Pinilla-Roncancio, Walsham, Van Minh, Neupane, Mai, Neupane, Blanchet and Kuper assert that the disabled face an increased risk of poverty, regardless of the measure of poverty. This risk is an international phenomenon, despite varying conditions and contexts. Even when the setting allows for economic prosperity, the disabled are likely to face relative poverty compared to the able-bodied. In a study examining multidimensional poverty in South Africa, Fransman and Yu revealed that race, unemployment, educational attainment and disability contributed towards poverty [11]. Furthermore, disability correlates with marginalisation and discrimination. Therefore, it can be inferred that there is a nexus between disability, exclusion and poverty. This implies that there is a need for interventions to limit and target the nexus between disability, exclusion and poverty, by ensuring policy decisions that cater and target such a nexus.

Access To Healthcare In South Africa

South Africa has a two-tier health system. The private health sector provides world-class medical care to those who can afford to pay, while the majority receive inferior care in the under-resourced public healthcare sector. Therefore, the quality of healthcare one can access in South Africa is largely dependent on socio-economic status. From the historic perspective, the apartheid regime imple-

mented inequalities in health and medical care for the majority Black populace. In the post-apartheid era, widespread disparities are still prevalent across racial and ethnic lines to access reasonable healthcare. Neely and Ponshunmugam affirm that the oppressive dehumanising apartheid regime and the macroeconomic policy of neoliberalism after apartheid resulted in underfunded and dysfunctional public health [12]. This is a major barrier to access healthcare, especially in rural areas. Although apartheid ended officially in 1994, Mhlanga and Garidzirai (2020) posit that race is still a major factor in the demand for healthcare services. Mhlanga and Garidzirai state that there is a huge difference in healthcare services provided by the private sector compared to the public sector. The private health sector spent 4.4% of its gross domestic product (GDP) to serve 16% of the population compared to the public health sector which spent 4.1% to serve 84% of the population in 2017. Furthermore, the 2016 General Household Survey (GHS) revealed that only 17 of 100 South Africans have medical insurance, and from the racial perspective 9.9% of the Black African households have medical insurance. A total of 52% of Indian households have medical insurance; Coloured households 17%, and the White population 72.9%. Therefore, it is evident that access to quality healthcare in the private sector is largely influenced by race. Mhlanga and Garidzirai also revealed other factors which influences access to healthcare in South Africa [13]. Private health facilities are very costly and out of reach for the majority. The cost of health services is the major impediment to access private healthcare. Furthermore, gender is also another determinant in the demand for healthcare. Women demand more health services than men. The size of the household also influences the choice of healthcare. Larger households tend to utilise the public health sector. It can be deduced that to access quality healthcare is largely determined by race and socioeconomic status. Furthermore, it can be deduced that residency in rural spaces adversely affect access to healthcare.

Batho Pele Principles and Provision Of Primary Healthcare

To improve public service provision, the South African government embarked on Batho Pele (people's first) campaign in 1997. This campaign comprises 'access' as one of its principles [14]. Khoza, Du Toit and Roos postulate that Batho Pele prescribes standards for public officials as an official government document [15]. The authors find a positive correlation between the implementation of the Batho Pele principles and increase in access to healthcare in the public sector, that is, different races receive the same standard of healthcare. The Batho Pele principles demands that healthcare professionals be impartial in their conduct and allow everyone access to the service, regardless of sexual orientation, gender, race and socio-economic status [16]. Although policy documents such as Batho Pele outlaws discrimination, especially based on sexual orientation, prevalent attitudes remain a barrier in the implementation of such policies when concerned with sexual minorities. Therefore, the lack of planning and change management adversely affected the implementation of the Batho Pele principles

National Health Act 61 of 2003

The National Health Act 61 of 2003 stipulates that the disabled patient must have informed consent to healthcare provision. Therefore, consultation with the patient to facilitate decision-making is necessary. In the case where the patient is unable to provide informed consent to receive a healthcare service, a person selected by the patient may consent thereto. Therefore, in the case of mental disability, the National Health Act stipulates that consent to receive healthcare is a requirement.

National Health Insurance

The National Health Insurance policy (NHI) aims to ensure universal healthcare coverage in South Africa, where everyone will have access to efficient and quality healthcare irrespective of socio-economic status. It proposes fundamental changes in the South African healthcare sector [17]. As per policy prescripts, private healthcare providers will be contracted to provide healthcare services to the public; and healthcare expenses will be covered by a single fund where a variety of funds will be pooled together. By 2013 the NHI was still in a pilot format when Matsoso and Fryatt reviewed its progress [18]. The NHI has features which are expected to be fully implemented by 2030 and these are inclusive of universal access; mandatory prepayment of healthcare; comprehensive services; financial risk protection; single fund; strategic purchaser; and single payer [19].

Constitution of the Republic of South Africa 1996 and Other Concepts

From the policy perspective, the Constitution of the Republic of South Africa of 1996, in its Bill of Rights stipulates access to healthcare services and the state is obliged to fulfil this right (Mutwali and Ross, 2019). Apart from the Constitution, South Africa is committed to the SDGs which embraces equitable access to healthcare. The Constitution of 1996 and the United Nations (UN) SDGs prescribe for state actors, not non-state actors. This implies that state actors must be leaders to ensure equitable access to healthcare. However, this fundamentally differs from the statement that Benatar et al make. Scholars argue that healthcare services are distorted, dysfunctional and unsustainable, because these are not geared to manage pandemics; fragmented; and has an element of a profit motive due to the private sector. Therefore, there appears to be a discord between Constitutional provisions and fundamental changes in the economy to facilitate the realisation of access to healthcare, especially quality healthcare for the disabled. Mutwali and Ross assert that disability encompasses impairments that are physical, mental, cognitive, sensory, emotional and developmental [20]. These impairments affect the ability to participate in society. Generally, the disabled are economically inactive. Consequently, they have a lower socio-economic status. It can be inferred that the shift towards health as a commodity in capitalist markets adversely affects access to healthcare for the disabled. concept of health policy implementation

Due to its complexity, this section will not include all aspects of policy implementation, and examine selected concepts as well as

provide a conceptual map because it relates to healthcare. Campos and Reich (2019) assert that implementation of the healthcare policy can become complex because the formulators do not implement the policy. Hence, a possibility of distortion and understanding of the policy. The authors further postulate that policy implementation requires clear communication of its objectives, availability of resources, need to ensure ownership by policy implementers, maintain conflict and cooperation as well as to manage amendments. This all happens in a context characterised by diversity among actors and organisations. Sætren and Hupe (2018) point out another factor which complicates policy implementation, namely: shift from government to governance, because more non-state actors are involved in most activities which was traditionally deemed the government's responsibility. This change correlates with the introduction of the tenets of New Public Management, namely: privatisation, decentralisation and contracting out. This has created market-corporate bureaucracy [21]. Therefore, implementation of the healthcare policy is largely affected by contemporary realities, unlike in the past when the state was the sole player of healthcare provision. Williams (2021) asserts that although the state is still deemed a major actor in economic and institutional development, the collective nature of various bureaucracies (both state and non-state) affects policy implementation [22]. Verdugo, Jenaro, Calvo and Navas (2017) posit that policy related to disability is subject to political, social and cultural factors. Therefore, it can be deduced that in the context of this paper, the social, political and cultural factors within King Cetshwayo District Municipality affects implementation in relation to the disabled.

Research Methodology

This paper adopted the qualitative research approach by focusing on policy implementation, a phenomenon with different actors and effects, which implies complexity. The qualitative approach was best suited to comprehend complex situations. Furthermore, the qualitative research approach allows the researcher to study the settings or contexts of the research participants, and validates the accuracy of the findings. Both primary and secondary data sources were utilised, primary data sources included in-depth interviews with academic experts in health, public health policy, epidemiology, biostatistics and medicine, and key informants from the Department of Health and non-governmental organisations (NGOs) who attend to the disabled. The secondary data sources included academic journals on policy and disability. In-depth interviews were conducted to yield a large amount of data, and enable the researcher to inquire about conflicting data. The research had a limited sample of ten respondents which comprised of academic experts, key informants from the Department of Health and NGOs who attend to the disabled. The small sample allowed comprehensive and intense data analysis (Robinson, 2014). The researcher utilised purposive sampling to identify respondents who have knowledge of the topic.

Discussion Of Findings

This section summaries the findings of the study gathered from

key informants from the Department of Health and NGOs who attend to the disabled within King Cetshwayo district municipality.

Presentation of Results

Disability is a universal phenomenon which affects all states and global regions, albeit differently. The disabled are victims of discrimination and disadvantaged by social institutions, society and their families. Furthermore, defining disability is difficult, because there is no agreement amongst scholars, policymakers and government authorities [23]. The United Nations Convention defines the disabled as “those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” and further defines disability as “a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors”.

The prevalence of disability may be due to health concerns (Leonardi et al., 2006), natural disasters, accidents and armed conflicts. Therefore, it is evident that no state can be spared of disability [24].

Conceptualisation of the Disabled

People living with disabilities conceptualise themselves as a community which is largely discriminated against by the broader community. The discrimination manifests itself as rejection. The concepts linked with discrimination are prevalent in the beliefs, language utilised to describe the disabled, and the lack of understanding their needs. The discrimination which the disabled face emanates from the household, and cascades to the community. One of the participant states that:

You find that in the community, once you are disabled, you become something that some consider that the disability grant is not something you deserve, as you are asked the question, ‘What are you going to do with it? (Uzoyenzi?)’. ‘What do you know about money?’ (Interview participant 1/23/3:34).

The language expressed above illustrates that the disabled are rejected and discriminated against, and at times treated as if they do not have their own needs. Furthermore, derogatory language is also used to refer to people with disabilities, and this language is characterised by words such as *isinqekle* (an isiZulu word for a person with amputated leg), *isishosha* (an isiZulu word for a person who cannot walk) or *impumputhe* (an isiZulu word for a person who cannot see). The community associate disability with confinement and the disabled are expected to be confined. The other emergent finding was the belief associated with disability, especially that it is a curse. This belief is prevalent amongst Black Africans.

When the language, discrimination and rejection the disabled face is considered, it aligns with the tenets of fundamental cause theory. The discrimination results in the disabled having limited access to

flexible resources (money, knowledge, power, prestige and beneficial social connections) [25]. This can be linked to the discrimination they face as well as rejection by society.

Therefore, it can be inferred that disability is generally conceptualised incorrectly, and the community still needs further education in this regard because the language utilised is insensitive for persons living with disabilities.

Spatial Concerns At Healthcare Facilities

Access to healthcare is characterised by disparities, which is a global phenomenon. In the South African context, the disabled are deemed vulnerable as far as access to healthcare is concerned (Visagie et al., 2015). To access healthcare facilities, the disabled face unsuitable spaces and some are somewhat confined.

I will explain accessing health as a disabled person. If you arrive at a clinic, our clinics are not....but now it is a little better as structures are getting more friendly. If you arrive there, firstly, you find that the place is not friendly, especially for us as people with disabilities, as we need more space for us to be able to access whatever we want to access. A confined space is not good for us. Space, the restrooms, we need the restrooms that are designed for us, and you find that clinics do not have such spaces (Interview participant 1/23/3:34).

Confined spaces suitable for the able-bodied, but not for the disabled can be ascribed to underfunding of the public health sector (Mayosi and Benatar, 2014). This can also be linked to the top-down approach utilised by the government which results in the lack of understanding of the community dynamics [26].

The second issue is covert discrimination in the form of parking spaces. In rural healthcare facilities, the disabled do not have adequate parking spaces. It is assumed that the disabled do not possess cars.

The very first effect is the parking spaces. There are very few parking spaces to cater for disabled persons. This has somehow led to the belief that disabled people cannot possess a car. (Interview participant 2/07/5:09).

Even when parking spaces are available, these are usually utilised by an able-bodied person, especially employees at a healthcare facility.

Needs of the Disabled

Disabilities are diverse; hence the disabled require alternative needs, which vary in types of assistance. The data revealed that the disabled require assistance, community understanding and prioritisation when accessing healthcare facilities. Their physical conditions and abilities are not the same as that of an able-bodied person. Visagie et al posit that the disabled are a vulnerable group concerning access to healthcare which is complex because they can develop other ailments while within a healthcare facility.

Secondly, even if the amenities are there, the place is conducive for a disabled person, you find that if I develop another ailment at the moment like I develop a running stomach, my ability to hold myself is not the same as yours, for you, you can say ‘my stomach is running’ and be able to run to the restroom, while I cannot do the same. These are the things which the members of the community do not understand why we have to take the first place, even when I came and find the queue very long. But when I come, because of my condition, it does not allow that I join the queue and wait for a longer period of time. So you find that the community just don’t understand that part. “We came here by 3 am and by 8 am someone just came and goes straight to the front.” (Interview participant 1/23/3:34).

The interview extract above indicates that there is a lack of understanding from the community about the needs of the disabled. Their needs are interconnected with their abilities and circumstances, which limits what they can do in response to various situations they may face while accessing healthcare facilities. It is not only the community that does not understand the needs of the disabled, healthcare professionals also do not.

After you have arrived in the healthcare facility, not all nurses understand that you need to be prioritised, as you have special needs. At times you arrive and you have to join the queue, like everybody in the queue. (Interview participant 2/07/5:09).

An interviewed participant felt that she was not prioritised in a healthcare facility. She was instructed to join the queue and resorted to protest action and left the healthcare facility without assistance and went to another facility.

Since the globe is facing the COVID-19 pandemic, the lack of prioritisation of the disabled in healthcare facilities may result in a multiple being infected. Their immune systems may be weaker compared to an able-bodied person.

Healthcare Professionals’ Behaviour And Attitudes

A lack of understanding disability among healthcare professionals, is also a phenomenon which the disabled face when they access healthcare professionals. Certain healthcare professionals in primary healthcare facilities do not consider that some issues need privacy and confidentiality. Consequently, the disabled are discriminated against in this regard.

You also find that disabled people have issues that are private and confidential, and in health facilities, the health professionals (nurses) do not recognise that we have issues that are private and confidential. Like the nurses will shout at you when you go to the clinic “What is that you came here for!?” (Uzokwenzani-ke!?)” in front of other patients. Then you wonder where is the privacy and respect of me as a person, because I am here, maybe I came due to a certain ailment, which is regarded as a private matter, for example, the sexually transmitted infections, and expectation of the community, the expectation of health professionals, they don’t expect a person

with a disability to do things that non-disabled people do (Interview participant 1/23/3:34).

Furthermore, linked to issues of privacy and confidentiality is the phenomenon of abnormal expectations by healthcare professionals of the disabled. For example, women with disabilities are expected to be sexually inactive. If they fall pregnant, they are deemed to have violated themselves. This results in emotional distress and accepting a status of disability is challenging for a disabled person.

Distance And Terrain

Distance and terrain are interlinked factors which affect the disabled when having to access healthcare. One respondent reported that she resides within 30 minutes walking distance from the healthcare facility, but due to her disability she has to hire a car to access the facility. Hiring a car, or accessing public transport in the form of minibus taxis and buses also has its challenges. One of these is poor treatment of disabled people. Vergunst et al revealed that the disabled face structural, geographical and attitudinal barriers relating to healthcare access [27]. Distance and terrain are largely geographical barriers and includes attitudinal barriers which has its roots in rejection and beliefs associated with disability.

Lack Of Government Action

The respondents indicated that apart from disability grants, the government does nothing to improve the lives of the disabled. In the interviews, no respondent mentioned the government department, and Department of Women, Youth and Persons with Disabilities; whose mandate is to “accelerate socio-economic transformation and implementation of the empowerment and participation of women, youth and persons with disabilities through oversight, monitoring, evaluation and influencing policy” (National Government of South Africa, 2021). This implies that the respondents are unaware of such a department or the department has not reached out to the disabled. The lack of government action is largely linked to the need for transport services to ensure access to healthcare.

Recommendations

Faculty/Department For The Disabled Within Healthcare Facilities
It is recommended that specialised faculties be established to meet the needs of the disabled within the healthcare system. This faculty should develop a database of all the disabled within the jurisdiction of the healthcare facility, profile each disabled person and implement a monitoring system to monitor the disabled and their healthcare needs. Within this faculty, caregivers must be employed to conduct regular checks and ensure that their healthcare needs are met. This will also help the disabled to minimise costs associated with access to healthcare, especially in rural spaces.

The facility for the disabled needs to be capacitated to manage any complexities which may arise as a result of disabilities. A disabled participant whose mother suffered a stroke, and rendered her helpless. Despite being disabled had to take care of her mother.

Such difficulties should be mitigated through a comprehensive health service. Proposals have been submitted to the Department of Health to consider a stroke as a disability.

Educational Workshops And Campaigns On Disability

Disability appears not be understood by the broader community. Government intervention is required in this area. The government and selected stakeholders need to host awareness and educational campaigns and workshops on disability. Proposals to include disability in the school curriculum has been submitted, especially at the primary level. This would help to counter the negative attitudes towards disability and dispel the belief that a disability is as a result of a curse. Furthermore, the community and political leaders also need to understand disability.

Proper Representation Of Disabled People In All Sectors

The disabled need to be represented in all sectors and a community representative who understands the challenges, concerns and conditions relating to disability would be a welcome relief. It is evident that the disabled are largely not represented, because most issues are presented able-bodied persons on their behalf.

Conclusions

This paper was based on the premise that much of scholarly research on healthcare access looks at disparities based on road networks and socio-economic factors, hence scarcity of research investigating policy implementation on healthcare access vis-à-vis disability in rural spaces. The results revealed that there is a need for proper conceptualisation of disability, because the terms utilised to describe the disabled are derogatory. The disabled face spatial concerns when accessing healthcare, although there have been recent improvements. The needs of the disabled are not understood clearly, and need to be prioritised when accessing healthcare. It also emerged that healthcare professionals’ attitude can be a barrier for the disabled when accessing the service. Rural residency factors such as the lack of alternatives, distance, terrain, and resources is linked to access healthcare. Policies related to accessing healthcare for the disabled appear to be limited, and there are issues of a lack of compliance. The disabled, as far as access to healthcare is concerned, face financial complexities as well as a lack of government action [28-77].

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